MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-029703

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7073 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB — AMENDED

VS 300 Rev. 4/59

FILED JUL 19 1963

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 5400 Arsenal St. St. Louis State Hospital — Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo — b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 5400 Arsenal St. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: William — Middle: F. — Last: Binz
4. DATE OF DEATH: Month: 7/5/63 — Day — Year
5. SEX: M.
6. COLOR OR RACE: W.
7. Married XX Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 2/24/98
9. AGE (last birthday): 65 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HR: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed
10b. KIND OF BUSINESS OR INDUSTRY: Hospt. Patient
11. BIRTHPLACE (City and state or country): St. Louis Mo.
12. CITIZEN OF WHAT COUNTRY: U.S
13a. FATHER'S NAME: Charles Binz
13b. MOTHER'S MAIDEN NAME: None
14. NAME OF HUSBAND OR WIFE: Millie Binz
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: Mrs. M. Binz 2232 St. Louis Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Epilepsy — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 353.3
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION — COUNTY — STATE

21. I attended the deceased from ____ to ____ and last saw her/him alive on ____
Death occurred at 6:20 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Helen L. Taylor, Coroner
22b. ADDRESS: 1300 Clark Ave.
22c. DATE SIGNED: 7-8-63

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 7/8/63
23c. NAME OF CEMETERY OR CREMATORY: New Bethlehem
23d. LOCATION (City, town, or county) (State): St. Louis Co. Mo.

24. FUNERAL DIRECTOR ADDRESS: Robert D. Kinealy 2228 St. Louis Ave
25. DATE RECD. BY LOCAL REG.: JUL 8 1963
26. REGISTRAR'S SIGNATURE: Hoad Smith M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED
2	2	13	
4	0		
5	1		
7	0		
8	2		
12	90-3		
	80		

BY AFFIDAVIT OF DOCUMENT

USE BLACK INK OR TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Herbert J. Glass Jr.

Licensed Embalmer No. 4800

P. O. Address Kirkwood 22 Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.